ADVANTAGE

...rising above the service you expect SM

State of Indiana
BENEFIT SUMMARY

Unless otherwise noted, all services must be provided, authorized or referred by the Member's Primary Care Physician

Annual Out-of-pocket Maximum (in-network) $1000 Single/$2000 Family

PHYSICIAN OFFICE SERVICES	MEMBER COPAY
Primary Care Physician Office Visits	$5 Copay per visit
Specialist Office Visits	$10 Copay per visit
Services include: • Routine health exams • Treatment of illness • Laboratory, X-ray and other diagnostic services • Immunizations	
Allergy tests (includes serum)	$0 Copay
Hearing exams	$0 Copay

OTHER SERVICES	MEMBER COPAY
Durable Medical Equipment, Prosthetic Devices, Corrective Appliances and Medical Supplies	$0 Copay
Short-term Therapies: Physical, Speech, or Occupational Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation	$0 Copay Outpatient – Limited to 60 visits for each distinct condition or episode.
Skilled Nursing Facility	$0 Copay
Home Health Services	$0 Copay
Hospice	$0 Copay

PRESCRIPTION DRUGS (Retail limited to 30 day supply; Mail Order limited to 90 day supply)	MEMBER COPAY Retail	Mail Order
Generic Preferred	$5 Copay	$10 Copay
Brand Preferred	$10 Copay	$20 Copay
Generic Non-Formulary	$15 Copay	$30 Copay
Brand Non-Formulary	$20 Copay	$40 Copay
Note: * Mandatory generic when available or member pays difference	Pre-packaged allergy medicines require a prescription	

INPATIENT HOSPITAL SERVICES	MEMBER COPAY
Semi-Private room and board, Private room if medically necessary **Services include:** • Operating, recovery room and other special units, including intensive care • Maternity care • Hospital ancillary services including lab, x-ray, EKG and other diagnostic services • Anesthesia, physical therapy and medications • Administration of blood and blood plasma • Physician and Specialist services	$0 Copay per admission

OUTPATIENT SERVICES	MEMBER COPAY
Outpatient surgery services, related lab and x-ray-services	$0 Copay per visit

EMERGENCY SERVICES	MEMBER COPAY
Emergency Room (in/out) (Copay waived if admitted)	$10/$25 Copay per visit
Urgent Care Center (in/out)	$10/$25 Copay per visit
Emergency Ambulance Services (Copay waived if transfer from one acute care inpatient facility to another)	20% Copay

MENTAL HEALTH SERVICES	MEMBER COPAY
Inpatient services	$0 Copay per admission
Outpatient services	$10 Copay

SUBSTANCE ABUSE SERVICES	MEMBER COPAY
Inpatient services (Detoxification: two admissions per Lifetime)	$0 Copay
Outpatient services	$20 Copay

EXCLUSIONS

- Services and supplies that are not performed, arranged, authorized, or approved in advance by the Covered Person's PCP, except in a emergency situation.
- Services and supplies that are not medically necessary
- Items or devices primarily used for comfort, such as television and telephone while in a hospital.
- Non-skilled care, rest cures, respite care, convalescent care or domiciliary care.
- Physical exams and related expenses, when provided for employment, school, travel, immigration, or insurance purposes.
- Orthodontia and other dental services, except as expressly stated in the policy.
- Cosmetic or reconstructive procedures and any related services or supplies unless deemed medically necessary.
- Services, drugs and supplies for weight loss, diet health or exercise programs, health club dues, or weight reduction clinics. Treatment for exogenous or morbid obesity, including but not limited to, gastric bypass, gastric stapling, gastric banding, or gastric balloon; liposuction or reconstruction surgery unless deemed medically necessary.
- All treatment, procedures, facilities, equipment, drugs, devices, services or supplies that are considered to be Investigational.
- Voluntary termination of pregnancy.
- Treatment of infertility and impotence; including drugs, testing.
- Hearing aids.
- Growth Hormones.
- Over-the-counter drugs.
- Other exclusions as described in the Certificate of Coverage.

LIMITATIONS

- Members must use the Plan's participating providers. These providers are subject to change from time to time.
- Members must live or work within the Plan's service area to remain covered by the plan.
- Members must select a PCP within a 30 mile radius of their residence.
- Mandatory Generic Substitution is required for all prescription drugs. If the Covered Person or the Covered Person's physician requests a Brand Name prescription drug and a Generic equivalent is available, the Covered Person will pay their applicable Copayment plus the cost difference for the Brand Name Drug.

COPAYMENTS

- Copayments must be made at the time services are rendered.
- Usual, customary and reasonable charges (UCR) are those commonly charged health service fees within a geographic area as described in the Evidence of Coverage.

ETHICAL AND RELIGIOUS DIRECTIVES

ADVANTAGE is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide services that are inconsistent with the medical ethics of the Catholic Church.

If you have any questions please contact ADVANTAGE Health Solutions at:
P.O. Box 80069
Indianapolis, Indiana 46280
(317) 573-6228 or (800) 553-8933, 7:30 a.m. – 5:30 p.m. (Monday-Friday)
TDD: 800-743-3333 (hearing impaired)

THIS SUMMARY IS A GENERAL OUTLINE OF COVERED BENEFITS UNDER YOUR PLAN AND DOES NOT INCLUDE ALL THE BENEFITS, LIMITATIONS AND EXCLUSIONS OF THE POLICY. PLEASE SEE THE GROUP POLICY AND/OR CERTIFICATE OF COVERAGE FOR SPECIFIC DETAILS.

VISIT OUR WEBSITE AT WWW.ADVANTAGEPLAN.COM